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AN ANALYSIS OF THE COMPUTATION OF DEPENDENT INPATIENT COSTS IN U.S. NAVAL HOSPITALS

by

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Thesis
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AN ANALYSIS OF THE COMPUTATION OF DEPENDENT INPATIENT COSTS IN U. S. NAVAL HOSPITALS

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INTRODUCTION

At various times during this nation's history, the Federal Government has operated business-type enterprises in the direct competition with private industry. It created the majority of these enterprises during periods of economic emergency and conflict, such as the depression and World Wars I and II; however, it continued the activities after the emergencies had terminated.

Following World War II, Congress repeatedly expressed its concern over the growth of these enterprises. At its direction, the second Hoover Commission studied and investigated various activities which were considered to be competitive with private enterprise. With regard to the military business enterprises, the Commission expressed in a statement of policy that:

> The Department of Defense is engaged in many business enterprises. It is our belief that all such commercial and industrial activities that can be effectively performed by private industry should be turned over to private industry. The burden of proof should be upon the Government to justify the continuation of present or inauguration of new commercial or industrial activities.[1]

The Commission listed and analyzed several reasons which were given to justify the Government's business enterprises. It dismissed the contention of the military departments that it was more economical to operate certain enterprises than to purchase the goods and services from private industry by stating that:

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[1] Commission on Organization of the Executive Branch of the Government, Subcommittee Report on Business Enterprises of the Department of Defense (Washington, D.C: Government Printing Office, 1955), p.1.

> In practically every case analyzed the Government's claim of more economical operation results from inaccurate or incomplete recording of costs. Costs submitted by the Government are rarely comparable with those of private industry, since they fail to include items such as military pay, retirement and other fringe benefits, rental value of facilities used, heat, light, and power, depreciation of equipment, management overhead, interest on investment (in land, buildings, equipment, and inventory), taxes--local, State and Federal--and profits of private industry subject to taxes.[2]

Prior to publication of the Commission's report, the Bureau of the Budget had already issued a Bulletin covering the operation of commercial-industrial activities of the Government. The Bulletin required that each executive department and establishment compile an inventory of all its commercial activities and evaluate each of these activities for the purpose of determining which products or services could be procured from private enterprise. It also outlined the costs which would be included in the cost comparisons.[3] The current Bulletin covering this same subject contains the following provision:

> . . . Costs. . . . The costs assigned to Government operation must cover all direct and indirect outlays, such as pay and other allowances for personal services and leave; contributions for retirement and disability; supplies; materials; transportation; warehousing; utilities; maintenance repairs, and similar factors. Appraisal of elements not usually chargeable to current appropriations, such as depreciation, interest on the Government's investment, ... the cost of self-insurance (even though it is unfunded), and exemption from Federal, State and local taxes . . . must also be made to the extent necessary to put the costs on a comparable basis. . . .[4]

The Department of Defense had issued instructions regarding the use,

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[2] Ibid. p. 10.

[3] U.S., Executive Office of the President, Bureau of the Budget, Bulletin No. 55-4. Commercial-industrial activities of the Government providing products or services for government use. (Washington, D.C.: January 15, 1955).

[4] U.S., Executive Office of the President, Bureau of the Budget, Bulletin No. 60-2. Commercial-industrial activities of the Government providing products or services for government use. (Washington, D.C.: September 21, 1959), pp. 2-3.

administration and review of the business-type activities under its control prior to issuance of the Bureau of the Budget Bulletin. Upon receipt of the Bulletin and in conformance with the policy concerning the costs, it issued a detailed set of cost principles and instructions covering the accounting methods to be used in determining the product and services costs of those industrial and commercial facilities owned and operated by the Department.[5]

Although it appears that the previously referenced directives apply only to business-type enterprises which are in competition with civilian industry, there are instances where the guidelines are applied in the determination of the costs of operation of a functional area or the provision of a service by a non-industrial activity. A good example is a comparative cost study which was recently conducted by medical department personnel of the Army, Navy and Air Force. The area under study was the providing of medical care to one category of patients--dependents of military personnel. The purpose of the study was to compare the cost to the Government to provide obstetrical and other medical care to these dependents in military hospitals versus the cost to buy similar care from civilian hospitals and physicians under a Government sponsored program.

The study was conducted as a special cost study since it required analysis beyond the normal accounting procedures of any of the military services. It involved the collection of costs for fourteen selected military hospitals for one year; the computation of the costs assignable to the various categories of patients, both as a cost per day and a cost per case; and the comparison of the computed costs with the actual charges to the

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[5]U.S., Department of Defense, Instruction No. 4100.23, Department of Defense Program for Review of Commercial and Industrial-type Activities. (Washington, D.C.: August 22, 1955).

Government for similar services from the hospitals and physicians in the adjacent communities. All direct and hidden costs which could be identified with the operation of the military hospitals were included. The costs were considered to be equally applicable to all categories of patients and were prorated accordingly. In addition,

> . . . An overhead cost factor of $5.55 per day was added to each calculation in the military hospital cost. This represents an agreed upon figure with the BOB to cover those cost items not directly discernible at the station level.[6]

Thus, every effort was made to ensure that the military costs were analyzed on a basis comparable to that used in civilian hospitals.

Underlying this cost study, and possibly the only reason for conducting it, is an assumption that if the Government can purchase obstetrical and other medical care for military dependents at a lower cost than the military hospitals can furnish it, the service should be purchased and the availability of medical care in military hospitals should be curtailed or discontinued. The study, then, should provide the data which is necessary to make a choice between the two alternatives. The situation is analogous to the common make or buy problem which occasionally confronts management in business and industry. Yet, the consideration and handling of the costs in the two situations are not the same. In the government study all costs are considered; in the business enterprise only differential or marginal costs (those which differ between the alternatives) are considered. The latter practice is equally applicable in civilian hospitals. In discussing special cost studies, the American Hospital Association states that:

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[6]U.S., Office of the Assistant Secretary of Defense, Letter with enclosure, from Shirley C. Fisk, M.D., Deputy Assistant Secretary (Health and Medical), to Hon. L. Mendel Rivers, Chairman, Subcommittee on Construction of Military Hospital Facilities, House of Representatives (Washington, D.C.: July 24, 1964). Printed in Hearings Before the Special Subcommittee on Construction of Military Hospital Facilities. 88th Cong., 2d Sess., 1964., p. 10342.

> When the management is analyzing the costs of alternative choices, it should consider the marginal costs. It is possible to make a comparison of the total costs that would be assigned to each alternative, but care must be taken to properly apply all allocated costs to both situations. However, the comparison can be accentuated by relating the costs which are peculiar to each activity and eliminating costs that are common to both alternatives.
>
> . . . . . .
>
> However, the point of analysis of marginal costs is to assess what costs will be added to or deleted from the total costs of the whole hospital due to the contemplated alternative. Only these are relevant to the decision since they measure the burden assumed or dropped by the hospital. . . .[7]

The author believes that the procedures discussed in the previous quote can be useful in determining which costs may be considered relevant in the computation of the cost of dependent care in military hospitals.

The purpose of this paper is to review the comparative cost study in the light of the American Hospital Association statement. No attempt is made to analyze the techniques which were used in the study or to develop new cost figures. Instead, the emphasis is directed toward the presentation and discussion of those factors which might affect the relevancy of the cost data. In other words, the writer hopes to present information which will support his contention that all of the costs which are assigned to dependent care will not, in fact, be saved if any part or all of dependent care is discontinued in military hospitals.

Since the missions, organization structures, staffing patterns, training programs and other areas differ between the three military services, the presentation of data is limited to one service--the U.S. Navy. Nevertheless, most of the information and conclusions may also apply to the U.S. Army and the U.S. Air Force. The following areas are discussed:

1. Who are the patients involved?--the historical background, legal

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[7] American Hospital Association, Cost Finding for Hospitals (Chicago: American Hospital Association, 1957), p. 92.

restraints, role and importance of dependent care in the naval medical sphere.

2. What was done?--a brief description of the basic cost study, mainly to familiarize the reader with the nature and types of costs involved and the manner in which these costs were prorated between the categories of patients.

3. Could it have been done differently?--a consideration of the missions of the Navy Medical Department and Hospitals, the determination and legal nature of staffing of medical facilities, the basic reasons for technical medical training and other areas which are considered pertinent.

CHAPTER I

WHO ARE THE PATIENTS INVOLVED?--THE MILITARY DEPENDENTS

In order to answer the question "Who are the patients involved?" this chapter discusses the particular group of patients which was the cause of the study--the dependents of military personnel. It presents a definition of those individuals who are considered to be dependents eligible for medical care; a discussion of the role that they play in the medical environment of the Navy; the background covering their entitlement to medical care; and a discussion of the question of whether medical care is a right or a privilege.

A Definition

The laws and service regulations are quite explicit regarding which individuals are entitled to medical care. The most current legislation defines a dependent as a person who has the following relationship to a member or former member of a uniformed service:

> (A) the wife;
> (B) the unremarried widow;
> (C) the husband, if he is in fact dependent on the member or former member for over one-half of his support;
> (D) the unremarried widower, if, because of mental or physical incapacity he was in fact dependent on the member or former member at the time of her death for over one-half of his support;
> (E) an unmarried legitimate child, including an adopted child or stepchild, who either--
> (i) has not passed his twenty-first birthday;
> (ii) is incapable of self-support because of a mental or physical incapacity that existed before that birthday and is, or was at the time of the member's or former member's death, in fact dependent on him for over one-half of his support; or
> (iii) has not passed his twenty-third birthday, is enrolled in

a full-time course of study in an institution of higher learning approved by the Secretary of Defense or the Secretary of Health, Education, and Welfare, as the case may be, and is, or was at the time of the member's or former member's death, in fact dependent on him for over one-half of his support; and

(F) a parent or parent-in-law who is, or was at the time of the member's or former member's death, in fact dependent on him for over one-half of his support and residing in his household.[1]

All of the above listed dependents are eligible, upon request, for medical care in facilities of the uniformed services, ". . . subject to the availability of space and facilities and the capabilities of the medical and dental staff."[2] However, only the wives, husbands and children of members of the uniformed services who are on active duty for a period of more than thirty days are eligible for medical care in civilian facilities.[3]

The Role of Dependents in the Medical Environment

The provision of medical care to dependents in naval medical facilities is an accepted and time-honored practice. The value of this practice is found in the many benefits which accrue to the Navy as a result of this service. The importance of these benefits has been stressed both in written reports and in testimony during hearings before Congressional Committees. Sources of this information include, but are not limited to:

1. A report of a Citizens Advisory Commission on Medical Care of Dependents of Military Personnel;[4]

2. The testimony of Vice Admiral J. L. Holloway, Jr., Chief of Naval

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[1]U.S., United States Code, 1964 Edition, Title 10, Section 1072.

[2]Ibid., Section 1076 [3]Ibid., Section 1079.

[4]Citizens Advisory Commission on Medical Care of Dependents of Military Personnel, Medical Care for Dependents of Military Personnel, A Report of the Citizens Advisory Commission appointed by the Secretary of Defense (Washington, D.C.: June 1953), pp. 12-13.

Personnel, during the House Subcommittee hearings on dependent medical care;[5]

3. The testimony of Rear Admiral B. W. Hogan, Surgeon General of the Navy, during the same House hearings;[6] and

4. The testimony of Rear Admiral E. C. Kenney, Surgeon General of the Navy, during the House Subcommittee hearings on the construction of military hospital facilities.[7]

From these references, it is possible to construct a listing of those factors or considerations which contribute to making the role of the dependent as important as it is. In turn, each of these factors or considerations contributes to the over-all effectiveness of the Navy.

The first consideration is the effect on the morale of naval personnel. Prior to World War II, the Navy was often referred to as a "bachelor Navy;" however, since then it has become a "married Navy." Accompanying this transition was an expected increase in the number of dependents. Since the objective of the Navy is to train and maintain effective fighting men, and since the concern of married men for the health and welfare of their dependents can seriously hamper their effectiveness, the Navy feels a strong obligation to look out for the dependents of its personnel. The assurance it gives that medical facilities are available for treatment of dependents helps to allay the worries of the Navy men and contributes to their peace of mind and devotion to duty.

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[5]U.S., House of Representatives, Committee on Armed Services, Subcommittee No. 2, Subcommittee Hearings on H. R. 7994, Dependent Medical Care Bill, 84th Cong., 2d Sess., 1965, pp. 5516-5517.

[6]Ibid., pp. 5765-5766.

[7]U.S., House of Representatives, Committee on Armed Services, Hearings Before the Special Subcommittee on Construction of Military Hospital Facilities. 88th Cong., 2d Sess., 1964, pp. 9987, 9992 and 10004-10005.

The second consideration is the effect on the practice of medicine. If the professional skill and versatility of the Navy medical officers are to be maintained during peace time, the treatment of dependents is a must. Without this group of patients, the medical officers can only look forward to treating generally healthy, young Navy men. Under these conditions, it would be almost impossible to interest any doctors in careers in the Navy. In effect, then, the dependent patients provide the opportunity for medical officers to engage in a more varied practice which helps to better qualify them clinically and professionally.

Third, the lack of dependent patients can adversely affect the training programs. It is through its training programs that the Navy is able to attract and retain many of the young medical officers who eventually become the career officers. The continued approval of these programs is dependent on the mixture of patients. It is therefore imperative that there be patients of both sexes and of all ages.

Finally, the provision of medical care to dependents can be considered an economical method. In peace time, the Navy maintains a portion of its medical capacity on a standby basis for emergency. The space and facilities for dependent care would be included in this portion if not in use. Thus, the care of dependents contributes to better utilization of medical personnel and facilities; in addition, it produces some economic return on the funds which are already invested in hospital plant property and staff.

Background of Medical Care for Dependents

The provision of some degree of medical care for dependents has been a practice for some time, even though there has not always been a law which specifically provided for such care. The first legal sanction for

the practice was furnished by the 48th Congress which included a provision in an Appropriations Act ". . . that the medical officers of the Army and contract surgeons shall, whenever practicable, attend the families of officers and soldiers free of charge."[8] Although there was no indication in the Act that the provision was permanent legislation, it was so treated and was incorporated, word for word, in the United States Code.

The Navy followed the practice of the Army and provided dependents with outpatient care, and inpatient care by Navy medical officers in other than naval medical facilities until 1943, when Public Law 51 was enacted by the 78th Congress. The Law provided for the expansion of facilities for the hospitalization of dependents of naval and Marine Corps personnel, defined the term "dependents," and authorized hospitalization of dependents for acute medical and surgical conditions, exclusive of nervous, mental, or contagious diseases or those requiring domiciliary care.[9]

The Army and Navy continued to furnish medical care to dependents of their personnel under the provisions of the two laws. In 1953, however, the Department of Defense determined, through studies, that there were approximately forty per cent of the military dependents who were not receiving medical care because military medical facilities were not always accessible. The Secretary of Defense therefore established an independent Citizens Advisory Commission to make a comprehensive study of the problem of medical and dental care for dependents of military personnel and to recommend any changes deemed appropriate for the establishment of a long range program for the administration of such care. Since the Commission was headed by Doctor

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[8]U.S., Statutes at Large, XXIII, 112.

[9]Ibid., LVII, Part 1, 80.

Harold G. Moulton, president emeritus of the Brookings Institute, it was referred to as the Moulton Commission. It was composed of five members, none of whom were connected with the Department of Defense, were a member on active duty or retired from the Armed Forces, or were connected with or a member of the medical, dental or allied professions.[10]

The Commission developed twelve questions for which it sought answers during its deliberations; these questions involved such areas as the operation of the present system, the rights of dependents to receive medical care, the advantages of having the care provided by the military establishment, the groups of dependents who should be eligible for such care, the types of illnesses which should be included, the financing of the medical care, and other issues which it considered pertinent. In the process, the Commission reviewed extensive memoranda, reports and other data available in the several Military Services, and held a series of hearings in order to obtain the views of such interested parties as representatives of the Services, the American Medical Association, the American Dental Association, the American Hospital Association, various veterans groups and a number of selected private doctors and dentists who had practiced within the military organization.[11]

After careful consideration of all significant aspects of the problem, the Commission stated that "it seems . . . highly inequitable to provide facilities for some dependents while others are excluded."[12] It

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[10]Citizens Advisory Commission on Medical Care of Dependents of Military Personnel, op. cit., pp. 1-2.

[11]Ibid., pp. 2-4.

[12]Ibid., p. 18.

therefore recommended that

> . . . The medical care program be broadened so that all eligible dependents be provided, as nearly as possible, with the same degree of medical care. Since the military medical facilities cannot, as a practical matter, provide all the services herein recommended, some other means of meeting the need must be provided. . . . It is obvious that the supplemental program must be provided by civilian medical facilities. . . .[13]

On the basis of the recommendations of the Moulton Commission, the Department of Defense proposed legislation for the purpose of providing medical-hospital care for all dependents, regardless of where they lived. The 84th Congress thoroughly studied, held hearings on and discussed the various issues involved in the legislation. The final outcome of this process was the enactment of the Dependent's Medical Care Act, which the President signed into law on June 7, 1956, to become effective December 7, 1956.

The Dependent's Medical Care Act is the current authority for providing medical care to dependents. It continues the practice of providing care at service medical facilities and, in addition, authorizes the use of civilian medical facilities to assure that medical care is available to spouses and children of active duty military personnel. It also directs the Secretary of Defense, after consulting with the Secretary of Health, Education and Welfare, to contract for such civilian services.[14]

Medical Care - A Right Or a Privilege?

The question of whether the entitlement of dependents to medical care is a right or a privilege has been raised on several occasions. One such instance occurred when the United States Court of Appeals for the 5th

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[13] Ibid., P. 19.

[14] U. S., United States Code, 1964, Edition, Title 10, Chapter 55.

Circuit considered a case involving the obligation of the Army to care for its dependents. A majority opinion cited the Act of 1884 and an Army Regulation and held that

> . . . the phrase "whenever practicable," as it appears in both the above statute and regulation, clearly stamps the obligation of the Government to provide medical service to Army dependents as discretionary in character.[15]

Then, in 1950, an Assistant General Counsel in the Department of Defense made an evaluation of the existing laws, regulations and other material concerning medical care for dependents in an effort ". . . to determine the extent to which these authorities require such care to be rendered... . ."[16] In a memorandum, he outlines and discusses the material as it applies to both the Army and the Navy. He concludes that

> Evaluation of all these authorities results in a determination that medical care for dependents of personnel of the services is on a conditional rather than an absolute basis. . . . all lead to the conclusion that medical care for dependents of military personnel is to be granted when a determination may be made that extra facilities exist after full care is given to personnel of the services and that no absolute obligation to care for all dependents is present in the law.[17]

The Moulton Commission also considered the issue as part of its deliberations. It stated in its report that ". . . if medical care were guaranteed as a right, there might be many times when the fulfillment of the obligation might not be possible because of the unavailability of personnel and facilities."[18]

Dr. Frank Berry, Assistant Secretary of Defense for Health and

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[15]Denny v. U.S., 171 Fed. 2d 365 (1949).

[16]U.S., Department of Defense. Memorandum from John G. Adams, Assistant General Counsel, to the Director, Office of Medical Services, Authority for Dependent Care (Washington, D.C.: January 18, 1950), p. 1. Signed copy on file in Bureau of Medicine and Surgery, Department of the Navy.

[17]Ibid., p. 14

[18]Citizens Advisory Commission on Medical Care of Dependents of Military Personnel, op. cit., p. 11.

Medical, again raised the issue in his statement during the House Subcommittee hearings on dependent medical care. He stated that

> Medical care for members of military families, with the Government participating in the cost, must remain a privilege and not a legal right of the individual. That was emphasized that in the case of war, that actually the serviceman, injured or ill, during the war would have first call on the facilities.[19]

Representative Wilson questioned Secretary Berry concerning the meaning of this particular paragraph of his statement. At this point, the Chairman, Representative Kilday, intervened and indicated that the passage alluded to the fact that ". . . a person who happened not to get medical care would have a course of action in the court of claims."[20]

Representative Blandford offered the following information about the handling of this issue in the Act:

> . . . Mr. Chairman, as a matter of fact, the bill as prepared very, very carefully spelled out the right to medical care, right as contrasted with the existing privileges--the right to medical care, but on a space and facilities available basis, with the further provision that any determination made in any facility by cognizant authority would be final and conclusive.
>
> . . . . . .
>
> . . . Now that is about as far perhaps as you can go in giving a vested right without bringing on a lawsuit, as the chairman has indicated would be the result because then you would have people testing in court the availability of the facilities. . . .
>
> So the determination has to be final and conclusive. So this is a right subject to a final and conclusive determination.[21]

All of the information given by Representative Blandford is included in the Dependent's Medical Care Act. In addition, there is a most important provision that the care of dependents may not be permitted to interfere with

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[19]U.S., House of Representatives, Committee on Armed Services, Subcommittee No. 2, Subcommittee Hearings on H. R. 7994, Dependent Medical Care Bill, 84th Cong., 2d Sess., 1956, p. 5533.

[20]Ibid., p. 5536

[21]Ibid., pp. 5536-5537

the primary mission of the facilities.[22]

It appears, then, that dependents do have a right to medical care; however, they do not have an absolute right to care in military medical facilities. This right is subject to one main condition--the availability of space and facilities and the capabilities of the medical staff, as determined by the cognizant authority. It is possible that in a period of emergency the facilities will be required for treatment of injured and ill servicemen and will not be available for treatment of dependents. If this occurs, the dependents will be required to obtain their medical care from civilian facilities. In view of this possibility, the author suggests that dependents should not be classified as a permanent category of patients with regard to their entitlement to care in military facilities, but rather should be classified as a semi-permanent category of patients.

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[22]U.S., United States Code, 1964 Edition, Title 10, Section 1076.

CHAPTER II

WHAT WAS DONE?--THE COMPARATIVE COST STUDY

As stated in the Introduction, the purpose of this paper is to review the comparative cost study, to discuss the nature of the included costs and the factors which affect the handling of these costs and to determine if all of the costs assigned to dependent care will be deleted if the care is discontinued. This chapter covers the review of the study. It presents general information concerning the requirement for and conduct of the study; a brief discussion of the cost accounting system in operation at U. S. Naval Hospitals; and a description of how the study was conducted at naval hospitals.[1]

General Information

Every few years, the military services conduct studies of the cost of treating dependents in military facilities and furnish the results to the Department of Defense and the Bureau of the Budget. On each occasion, the special cost studies are necessary because it is not possible to obtain the desired information from the statistics and accounting records which are routinely collected and maintained. Knowing this, persons outside of government may ask why the information is not available for military medical

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[1]Unless otherwise footnoted, the information presented in this Chapter is the result of experience gained by the author while he was a member of an ad hoc study group appointed by the Deputy Assistant Secretary of Defense, Health and Medical, for the purpose of conducting a comparative cost study on military and civilian hospitals.

General Information

Every [illegible] activity [illegible] of the [illegible] of [illegible] [illegible] [illegible]

facilities when it is so readily available for civilian facilities. Since the primary objective of both facilities is to care for the sick and injured, this is a logical question. Yet, the answer to this particular question lies not in the fact that treatment is given, but in the difference in the amount and manner of payment for the services which are rendered.

With regard to civilian hospitals, the American Hospital Association points out that

> The amount and method of payment to hospitals should be such as (1) to pay fairly and adequately for services rendered, (2) to maintain essential services, and (3) to encourage the development of higher standards of service to meet the needs of the community.
>
> . . . The hospital administrator, the governing board, and the medical staff must have assurance that the amount and method of payment will be adequate to cover the current costs of providing the services which are requisite to necessary care, and that payments can be adjusted from time to time to meet the cost of expanded and improved quality of care.[2]

Thus, each civilian hospital faces an involved task when computing the charges to patients. It must collect detailed statistics and maintain detailed accounting records. This information is necessary if the hospital is to properly bill an individual patient for room and board and, in addition, for such special services as use of the operating room, the delivery room, the radiology and laboratory departments, oxygen therapy, anesthesia, the pharmacy and other areas.[3]

On the other hand, none of the military hospitals compute the charges for individual patients. In those cases where charges for services are required and made, all of the hospitals make collections at various standard rates, depending on the status of the patient. For instance, in the case of dependents, the hospitals collect $ 1.75 per day for inpatient care as

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[2]American Hospital Association, Principles of Payment for Hospital Care, Publication G185-rev. (Chicago: American Hospital Association, August 1963), pp. 3-4.

[3]American Hospital Association, Cost Finding for Hospitals (Chicago: American Hospital Association, 1957). p.22.

required by regulation.[4] In addition to this local collection, the law provides that

> If a person receives inpatient medical or dental care in a facility of a uniformed service other than that of the member or former member concerned, the appropriation for maintaining and operating that facility shall be reimbursed at rates established by the Bureau of the Budget to reflect the average cost of providing such care.[5]

Thus, the Navy is reimbursed by the Army and Air Force for treatment of the respective personnel and their dependents in naval hospitals, and vice versa.

The previous quotation includes two points which deserve further discussion. First, medical facilities are provided operating funds by the Congress in the form of appropriations. For instance, in the Navy, ". . . the operation and maintenance of naval hospitals and medical centers are funded by the appropriations Operation and Maintenance, Navy (Medical Care) and Operation and Maintenance, Navy (Civil Engineering). . . ."[6] Because of this, military hospitals do not have to depend on the income from patients to cover operating costs as do the civilian hospitals.

Second, the Bureau of the Budget has established the rates for hospitalization and has furnished this information to the various governmental departments and agencies for promulgation. It established the original rates in 1956, on the basis of information obtained from a special dependent care cost study conducted by the military services. It has updated these rates periodically to reflect increases in prices, wages and other economic factors. It is noted with interest that the current general rate, unlike most civilian hospital charges, covers both professional services and hospital services,

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[4]U.S., Department of the Navy, SECNAV Instruction 6320.8B, Medical Service: Dependents' Medical Care (Washington, D.C.: 13 July 1964), p.20

[5]U. S., United States Code, 1964 Edition, Title 10, Section 1085.

[6]U. S., Department of the Navy, Bureau of Medicine and Surgery, Financial Management Handbook, Publication NAVMED P-5020 (Washington,D.C.: March 1961), p. 1-1. Hereinafter, referred to only by title.

including room, board and general nursing.[7]

Special dependent care cost studies were conducted during 1956, 1958, 1962 and 1964. The study groups generally consisted of several representatives from the Bureau of the Budget and the Department of Defense, and one representative from each of the three services. Although each group established its own ground rules, procedures and techniques, it appears that the latter groups followed a pattern or program established by the earliest group. The 1956 group provided the necessary data for establishment of a reimbursement rate; the succeeding groups provided the data required for updating the rate. In addition, the 1964 study group conducted a more detailed study than those of the previous groups. It was required to determine not only the cost per patient day and cost per case for all dependents, but also, and more specifically, the cost per patient day and cost per case for obstetrical dependent patients.[8]

All of the study groups worked within the bounds of the prescribed Bureau of the Budget system of determining hospital costs. This system is used by Federal agencies ". . . in reporting data on the cost of operation, ration costs, bed capacity and patient loads, and personnel for various types of Federal hospitals and domiciliary facilities. . . ."[9] It requires the collection of costs by various functional areas. Those functional areas which enter into the computation of the cost per patient day in naval hospitals are shown in Table 1.

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[7]U.S., Department of the Navy, Bureau of Medicine and Surgery, BUMED INSTRUCTION 6320.4M, Medical care, subsistence rates, and hospitalization bills; cost elements of (Washington, D.C.: 6 January 1966), p. 4

[8]U.S., Department of the Navy, Bureau of Medicine and Surgery, Various Memoranda for the Record (Washington, D.C.: 1956 through 1964)

[9]U.S., Executive Office of the President, Bureau of the Budget, Instructions for Preparation of Statistical Reporting Forms for Federal Hospitals (Washington, D.C.: July 1960), Introduction.

TABLE 1

FUNCTIONAL AREAS OF EXPENSE FOR INPATIENTS IN NAVAL HOSPITALS[a]

Item	Decription	Expenses Included
1	Administration	The cost of administration and business management, including the executive offices; personnel; finance; switchboard service; and supply activities.
2	Professional Care of Patients	The cost of professional medical and dental staff (full-time, part-time, and consultant); nursing service; ward service; operating suites; clinical services such as X-ray, laboratory and pharmacy; and medical administrative expense such as admission office, registrar's office, and clinical records office.
3	Dietetic Service	The cost of operation of the dietetic department, including all kitchens and dining rooms for patients, members, and personnel.
4	Recreational Service	The cost of salaries and all other expenses incurred for chaplaincy, recreational or library activities.
5	Maintenance and Operation of Buildings and Grounds	The costs of all expenses incident to the operation and/or general maintenance of buildings and grounds, including utility distributing systems; fire and police protection; and housekeeping functions.
6	Laundry Service	The costs of all expenses incident to laundry operation.
8	Transportation	The cost for transportation, hauling and drayage incident to the operation of all activities of the facility.
11	Furniture, Furnishings and Equipment	The cost of all furniture, furnishings, equipment, and other non-expendable property, issued for in-patient activities

[a]Adapted from Bureau of the Budget, Instructions for Preparation of Statistical Reporting Forms for Federal Hospitals (Washington, D.C.: July 1960).

Table 1

Comparative Value of Species for Electricity
in River Districts

Item	Description	Comparative Estimates
1	[illegible]	[illegible]
2	[illegible]	[illegible]
3	[illegible]	[illegible]
4	[illegible]	[illegible]
5	[illegible]	[illegible]
6	[illegible]	[illegible]
7	[illegible]	[illegible]
8	[illegible]	[illegible]
9	[illegible]	[illegible]
10	[illegible]	[illegible]

[illegible]

In addition, the Bureau of the Budget requires that the costs for each functional area be itemized according to the type of expense involved. The various types of expense are shown in Table 2.

TABLE 2

TYPES OF EXPENSES INCLUDED UNDER FUNCTIONAL AREAS IN NAVAL HOSPITALS[a]

Type	Description	Expenses Included
1	Salaries	The total expenditures for personal services of full-time, part-time, or consultant employees and residents, interns, student nurses, and other trainees. The gross salary of civilian personnel and the pay and all allowances of commissioned and enlisted personnel.
2	Supplies and Materials	The cost of all expendable supplies and materials (exclusive of subsistence supplies) actually issued.
3	Subsistence Supplies	The cost of only the actual food.
4	Furniture, Furnishings and Equipment	The cost of all furniture, furnishings and equipment actually issued, whether replacement or initial equipment items.
5	Other Expenses	The cost of all expenses which cannot be properly distributed among the four previous items. Includes all fee payments for medical and dental services, medical and dental laboratory services and other special services such as blood transfusions; all services furnished by contract such as utilities, construction work, maintenance, laundry, telephone, etc.; rentals; transportation, travel and postage expenses; and freight and express charges.

[a]Adapted from Bureau of the Budget, Instructions for Preparation of Statistical Reporting Forms for Federal Hospitals (Washington, D.C.: July 1960).

The total of the various expenses under all the functional areas represents the gross cost of operating the inpatient facilities. However, this total includes certain costs which are initially charged to the inpatient functions, but which are applicable to non-inpatient areas. Examples include, but are not limited to, the furnishing of X-ray, laboratory, pharmacy and other clinical services to outpatients; the sale of meals; the provision of meals to personnel not attached to the hospital or not working in inpatient areas; and the furnishing of maintenance, utility and laundry services to non-inpatient areas. In those hospitals where any examples of this type are found, a proportionate share of the gross cost of the applicable function is transferred out of inpatient costs on the basis of the appropriate workload units. When this is done, the costs which remain are the net operating costs. The cost per patient day is then computed by dividing the net operating costs for the period by the total patient days for the same period.[10]

It should be stressed that the resultant cost per patient day is an average cost for treating all patients without regard to category of patient, i.e., active duty, dependent, retired, medical, surgical, obstetrical or other. There is no existing regulation which requires that the costs for military hospitals be computed in such detail.

The Cost Accounting System at U. S. Naval Hospitals

Although the Bureau of the Budget has prescribed the format for reporting the annual operating costs of Federal hospitals, it has not imposed a standard cost accounting system that all agencies must use for collecting the data. Instead, each agency has developed an accounting system which it considers best satisfies the needs of its management at all levels.

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[10] Ibid., p. 3.

[10]Ibid., p. 3.

In developing a cost accounting system for use at naval hospitals, the Navy has employed the same functional structure and numbering pattern which the Bureau of the Budget has prescribed for its annual report. It has called the major functional areas Budget Functions. Since the areas are too broad for management review and control purposes, the Navy has further divided the structure into Cost Centers which ". . . reflect the cost of operating selected departments, units, functional areas or activities. . . ."[11] A listing of the inpatient Budget Functions, with respective Cost Centers, which were in use at the time the information used in the 1964 cost study was collected is contained in Table 3.

TABLE 3

INPATIENT BUDGET FUNCTIONS AND COST CENTERS IN USE AT NAVAL HOSPITALS, FISCAL YEAR 1963[a]

Budget Function	Cost Center	Description
1		Administration
	00	Accelerated Costs
	01	Command Support
	02	Fiscal - Supply
	03	Staff Personnel
	04	Maintenance
	05	Communications
	06	Government Contributions (Benefits for Civilian Personnel)
		Professional Care of Patients
2	07	Medical Records Administration
	08	Inpatient Functions
	09	Radiology Service
	10	Pharmacy Service
	11	Laboratory Service
	12	Dental Service
	13	Outpatient Functions (Clinics)
3		Dietetic Service
	14	Maintenance & Operation, Dietetics
	15	Provisions

[11] Financial Management Handbook, op. cit., p. 2-45 (Ch. 5-2).

TABLE 3-- Continued

Budget Function	Cost Center	Description
4	16	Recreational Service
5		Maintenance & Operation, Buildings and Grounds
	17	Security - Fire Protection
	18	Maintenance Shops
	19	Housekeeping - Janitorial
	20	Buildings
	21	Grounds - Roads
	22	Electrical Distribution System
	23	Steam Heat Distribution System
	24	Gas Distribution System
	25	Water Distribution System
	26	Sewage - Refuse Disposal
	27	Air Conditioning - Refrigeration Service
6		Laundry Service
	28	Maintenance & Operation, Laundry Service
	29	Contract Laundry
8		Transportation Service
	30	Maintenance - Transportation Service
	31	Operation - Transportation Service
11		Furniture, Furnishings and Equipment
	32	Plant Property
	33	Minor Property

[a]Adapted from: Department of the Navy, Bureau of Medicine and Surgery, Financial Management Handbook, Publication NAVMED P-5020 (Washington, D. C.: March 1961).

Within this structure, Naval Hospitals follow a procedure prescribed by the Comptroller of the Navy which requires that all activities analyze individual transactions by functional accounts and object classifications. The functional accounts are five-digit accounts which ". . . generally analyze expenditures by the use made of manpower, material and services. . ."[12]

[12]U. S., Department of the Navy, Office of the Comptroller, Accounting Processes (Washington, D.C.; 1 July 1962), p. 13.

Section	Item	Description
1	01	[illegible] Service
2		Maintenance & Operating Buildings and Grounds
	07	Electric — City Franchise
	08	Gas Franchise Taxes
	09	Telephone — Exempt
	10	Water
	11	Sewage — Basic
	12	Electrical Distribution System
	13	Steam Heat Distribution System
	14	Air Conditioning System
	15	Fire Protection System
	16	Steam — Other Systems
	17	Air Conditioning — Refrigeration Service
3		Laundry Service
	18	Maintenance & Operating Laundry Service
	19	Laundry Labor
4		Transportation Service
	20	Maintenance — Transportation Service
	21	Operation — Transportation System
5		Purchasing, Receiving and Shipping
	22	Labor Expense
	23	Other Expense

Adapted from: Department of the Navy, Bureau of Medicine and Surgery, Standard Accounting Systems Publication (Washington, D.C.: Navy Dept., 1961).

Within the structure, Navy hospitals differ somewhat in the Commission of Functional Codes for cost classification by functional category or clinical service [illegible] type classification of the use made of equipment, personnel or [illegible]

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[1] U.S. Department of the Navy, Bureau of the [illegible] Standard Accounting Systems (1961), p. 1.

The use and meaning of these accounts are standardized for the entire Navy. For instance, account 43211 always indicates the Military Personnel Office, 77115 the Surgical Service, and 77171 the Obstetrics& Gynecology Service.

Object classifications, on the other hand, are two-digit numbers which furnish an ". . . analysis according to the types of services, articles, or other items involved. . . ."[13] Information collected under each of these numbers is a detail of one of the types of expense shown in Table 2. Although the Bureau of the Budget is the basic authority which requires use of these numbers, it is the Comptroller of the Navy who prescribes the use of the classifications shown in Table 4 within the Navy.

TABLE 4

OBJECT CLASSIFICATIONS USED WITHIN THE NAVY[a]

10 PERSONAL SERVICES AND BENEFITS
- 11 Personnel compensation
- 12 Personnel benefits
- 13 Benefits for former personnel

20 CONTRACTUAL SERVICES AND SUPPLIES
- 21 Travel and transportation of persons
- 22 Transportation of things
- 23 Rent, communications, and utilities
- 24 Printing and reproduction
- 25 Other services
- 26 Supplies and materials

30 ACQUISITION OF CAPITAL ASSETS
- 31 Equipment (Plant & minor)
- 32 Lands and structures
- 33 Investments and loans

40 GRANTS AND FIXED CHARGES
- 41 Grants, subsidies, and contributions
- 42 Insurance claims and indemnities
- 43 Interest and dividends
- 44 Refunds

[a]Source: Department of the Navy, Navy Comptroller Manual, Volume 2, Chapter 6.

[13]U.S., Executive Office of the President, Bureau of the Budget, Circular No. A-34, Instructions Relating to Apportionments and Reports on Budget Status (Washington, D.C.: July 1960), Sec 21.

As if the accounting structure discussed thus far is not complicated enough, the individual hospitals are encouraged to establish any further subdivisions for the collection of information which local management considers necessary for review and control purposes. Most, if not all, of the hospitals have considered this step necessary and have established job order numbers for the collection of costs for all of the individual working areas or units, many of which are classified under the same functional accounts. If all of the levels of the cost accounting system were put together, a sample of an abstract from the structure at any naval hospital might be as shown in Table 5.

TABLE 5

SAMPLE COST ACCOUNTING STRUCTURE AT A NAVAL HOSPITAL

BF 2 Professional Care of Patients

CC 08 Inpatient Functions

FAN 77115 Surgical Service
JO 8372 Main Operating Room
OC 11 Personnel compensation - military
OC 25 Other services
OC 26 Supplies and materials
JO 8370 Surgical Service Wards
OC 11 Personnel compensation - military
OC 26 Supplies and materials
JO 8377 Anesthesia Service
OC 11 Personnel compensation - military
OC 26 Supplies and materials

FAN 77171 Obstetrics & Gynecology Service
JO 7845 Obstetrics Delivery Room
OC 11 Personnel compensation - civilian
OC 11 Personnel compensation - military
OC 26 Supplies and materials
JO 7843 Obstetrics & Gynecology Service Wards
OC 11 Personnel compensation - civilian
OC 11 Personnel compensation - military
OC 26 Supplies and materials

Notes: BF - Budget Function; CC - Cost Center; FAN - Functional Account; JO - Job Order Number; and OC - Object Classification.

[illegible] [illegible] [illegible] [

This, then, is the framework in which naval hospitals accumulate the cost data required for reporting to higher authority; for reviewing, analyzing and taking appropriate action regarding the wise use of resources; and for planning and budgeting for future operations. The detail of the framework varies from hospital to hospital, depending on the size of the hospital, the complexity of its organization, and amount of detailed data required by its management. Regardless of the variance as to the amount of detail, all naval hospitals use standard procedures for recording transactions in the accounting records and for reporting summary data to the Bureau of Medicine and Surgery, Navy Department.

With regard to the recording procedures, all hospitals operate under an accrual accounting concept whereby costs are recognized in the fiscal period during which the benefits (material or services) are received, regardless of the time of payment.[14] For instance, the amount of civilian labor earned during a fiscal period is charged as a cost in that period even though it is paid the next fiscal period. This same procedure is followed in the handling of equipment purchases; the total acquisition price of the item of equipment is charged as a cost in the period in which it is received. In this respect, the accrual accounting system in use in naval hospitals differs from conventional systems in which equipment purchases are capitalized and the costs are charged as depreciation to the periods benefiting from their use. However, it should be pointed out that hospitals are classified as nonindustrial activities and as such are not required to practice depreciation accounting, In addition, the Bureau of the Budget requires that equipment acquisitions be handled in the same manner as is being done in the current procedure.

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[14] Financial Management Handbook, op. cit., p. 2-2-1 (Ch. 5-2)

There are two other collecting and recording procedures which deserve special mention--the handling of compensation for military personnel and the handling of materials and services which are either donated to the hospital or received without charge. In handling the first procedure, hospitals charge the pay and allowances of military personnel to cost at basic standard compensation rates rather than the actual amounts of payments. They record the applicable costs under the various structural components at the end of each month, depending on where the personnel are working. To determine these costs, the hospitals use the basic rates which, although developed by the Department of Defense, are prescribed by the Comptroller of the Navy. These rates represent the weighted averages for each pay grade; they were developed by using the actual basic pay and allowances and the best available data as to the number of personnel in each pay grade according to length of time in service. The rates include such elements as pay based on length of service, quarters and subsistence allowances, maintenance and clothing allowance for enlisted personnel, and the Government's contribution under the Federal Insurance Contribution Act.[15]

The other procedure involves the receipt of materials and services by the hospital without charge to its regular operating funds. These receipts occur when non-military persons or organizations donate items of equipment or supplies, when other governmental activities declare items of equipment and supplies as excess property and the hospital obtains it at no cost, and when other naval activities furnish a support-type service on a continuous basis. Examples of the latter include fire and police protection, military payroll functions and preparation of civilian employee pay checks.

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[15]U.S., Department of the Navy, Comptroller of the Navy, Navy Comptroller Manual, Volume 2, Article 035750.

As these receipts occur, naval hospitals record amounts in the appropriate slot in the accounting structure, based on the fair-market or estimated value of the donated items, the book value of the excess items, or the computed or estimated value of the support-type service as given in a memorandum from the activity furnishing the service.

Thus, every attempt is made to collect and record the costs of all the resources which are used in the operation of the hospital. These costs cover not only the resources which are procured with funds from allotments issued to the hospital, but also those which are furnished by outside individuals and groups and other governmental activities.

With regard to the reporting procedures, all naval hospitals submit cost reports every three months to the Bureau of Medicine and Surgery, in accordance with instructions issued by that Bureau. Since all of the hospitals have some type of data processing machines, they submit (1) a Financial Performance Report (Machine Summary Listing) detailed to the levels of Budget Function, Cost Center, Functional Account and Object Classification; and (2) a deck of punched cards composed of one card for each line item on the Summary Listing.[16] Through use of the reports and the cards, the Bureau makes analyses of the hospitals and prepares a composite annual report for submission to the Bureau of the Budget.

The Actual Study

The dependent care cost study which is the subject of this paper was conducted from January to June 1964. It centered around fourteen military hospitals, three of which were the U.S. Naval Hospitals, Newport, R.I.;

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[16] Financial Management Handbook, op. cit., Chapter II, Part 7, Section 2 (Ch. 5-2).

[illegible]

[illegible]

[illegible]

Philadelphia, Pa.; and Portsmouth, Va. The period of time covered by the study was Fiscal Year 1963, which began July 1, 1962 and ended June 30, 1963.

As stated previously, the purpose of the study was to determine if it is cheaper for the Government to provide dependent medical care in military or civilian hospitals. It was therefore required that cost information be available for both the selected military hospitals and the adjacent civilian hospitals. The Office for Dependents' Medical Care, Denver, Colorado, furnished the cost per patient day and the cost per case figures for both obstetrical and all other dependent patients for the civilian hospitals, based on the actual charges to the Government for the period. It was the job of the representatives of the services to furnish the same cost figures for the military hospitals.

The study was conducted in the same manner at each of the naval hospitals, using the procedures and techniques that were used in the previous dependent cost studies. Each study was completed in the following three steps:

1. the accumulation of detailed cost data for fiscal year 1963;

2. the accumulation of the statistics necessary for (a) prorating the costs between dependents and all other patients, and (b) prorating the dependent costs between obstetrical and all other dependent patients; and

3. the actual proration of the cost data using the available statistics.

The accumulation of the detailed cost data presented no problems. The costs by Budget Function, Cost Center, Functional Account, and Object Classification were taken directly from the quarterly cost reports. Thus, the data regarding costs for civilian and military labor, supplies, equipment and the various services was readily available for most of the work

areas. However, since Cost Center 08, Inpatient Functions, combined many of the important treatment areas under common functional accounts and since these areas would be most involved in the prorations, the individual hospitals were requested to and did furnish a detailed breakdown of the total costs charged to this Center by Job Order number. The costs were then available for various treatment areas, such as the Operating Rooms, Central Supply, Cast Room, Delivery Room, Nursery, and others.

A proportionate share of the total inpatient costs which was assignable to outpatients and persons working in non-inpatient areas was transferred out of the applicable Cost Centers and Job Orders so as to obtain strictly net inpatient costs. These net costs were the costs which would be prorated between the dependent inpatients and all other inpatients.

The accumulation of the statistics, on the other hand, presented a considerable number of problems. First, there was, and still is, no requirement to keep the statistics in the detail necessary to conduct this type study. Inpatient statistics on dependents were available as a group rather than as obstetrical, medical, pediatric or other. Second, six to nine months had elapsed since the end of the fiscal year. In some cases, the informal records of statistics had been destroyed, since there was no requirement that such information would be collected, or if collected, would be retained. In any event, every effort was made to accumulate those statistics which were available and could be used.

In those cases where adequate statistics were not available, a proration procedure used by the previous study groups was followed. Under this procedure, if appropriate workload information was not available, the costs for the particular area were prorated on the basis of the Average Daily Patient Load or the admission rate. In some cases, judgment factors

were introduced, and it was decided by individuals of the hospital and the study group representative that the procedure should be adjusted. For instance, if statistics were not available for the Laboratory and X-ray Services, the costs were usually prorated on the basis of the admission rate per cent, assuming that all patients use these services at that time. However, obstetrical patients usually have their chest X-rays and continuous Laboratory work done prior to admission, with no X-rays and little laboratory work done upon admission. In view of this and the high admission rate for this category of patients, the usual procedure was not considered applicable and was therefore changed. Likewise, for the Cast Room, Electroencephalograph and Electrocardiograph Units, the procedure was to prorate on the basis of the average daily patient load, thereby assuming that all patients had equal access to use of the facilities, Again, however, the procedure was changed because it was considered the exception when OB-GYN patients used these facilities. A listing of some of the statistical data which was used at the Naval Hospital, Philadelphia, is shown in Table 6.

Once the detailed cost data and the statistics were accumulated, the proration of the costs between categories of patients was a mechanical procedure. For the Budget Functions covering Administration, Transportation Service and Furniture, Furnishings and Equipment, the costs were prorated by using the average daily patient load. For the Recreational Service, a certain percentage of the Chaplaincy costs as determined by the Chaplain was prorated to Dependents; all of the recreational costs were assigned to all other patients as these costs were not considered as being applicable to dependents. The Laundry Service was usually prorated on the basis of the admission rate per cent since detailed records were not on file by consuming work areas. The maintenance and operation of buildings and ground costs

TABLE 6

SELECTED STATISTICAL DATA, FISCAL YEAR 1963
U.S. NAVAL HOSPITAL, PHILADELPHIA, PA.[a]

Average Daily Patient Load (ADPL)		
Total Patients	834	
Dependents	101	12.11%
All Others	733	87.89%

Dependent Average Daily Patient Load		
Total Dependents	101	
Obstetrics (OB)	24	23.76%
All Others	77	76.24%

Patients Days		
Total Days	304,466	
Dependents	36,871	12.11%
All Others	267,595	87.89%

Dependent Patient Days		
Total Days	36,871	
Obstetrics	8,760	23.76%
All Others	28,111	76.24%

Admission Rate		
Total Admissions	11,994	
Dependents	4,709	39.26%
All Others	7,285	60.74%

Adjusted Admission Rate (Less OB)		
Total Less OB	10,246	
Deps. Less OB	2,961	28.90%
All Others	7,285	71.10%

Adjusted ADPL (Less OB-GYN Patients)		
Total (Less OB-GYN)	794	
Deps. (Less OB-GYN)	61	7.70%
All Others	733	92.30%

[a]Source: Adapted from working papers of Navy Representative of Study Group on file in Department of the Navy, Bureau of Medicine and Surgery.

were prorated to dependents on the basis of space occupied by that category of patients compared with total space available and in use.

The most detailed prorations were made in the professional care areas. Under the inpatient functions, the prorations were made at the Job Order Level. The costs of the Pharmacy, Laboratory, X-ray, Dental and Medical Records Sections were all handled at the Cost Center level. In any event, each individual work area was reviewed and an attempt was made to make an unbiased assignment of costs to the dependent patients.

The same procedure was performed a second time in order to prorate the dependent costs between obstetrical patients and all other dependents.

Issue 4

Sporting Association Ltd. Notice Year 1941
c.c. Silver Bowling Tournament, Ta.

Bowling Entry Closing Date (cont.)

Pearl Jacksons	814		Dusty Greenwood	721	
Shepherdbury	780	11,121	Jamestown (WP)	71	11,863
All Others	715	17,453	All Others	74	17,742

Fielders Data

Silver Bays	1hr,04m		Twin Cove	8h,41m	
Shepherdbury	7h,21m	11,111	Jamestown	7,78	11,863
All Others	7hr,2m	17,453	All Others	8,12	17,742

Fielding Tee

Twin Peninsula	11,114		Twin Inn B	8h,12	
Shepherdbury	7,3m	11,121	Mayn. Inn B	7,78	11,863
All Others	7,201	17,453	All Others	7,814	17,742

Bellwood Inn Town Tournament

Twin Pine Inn	10-0	Pts
Bays. Pine Inn	10	11,78
All Others	711	17,3m

Tennis. Another fine outing today at Bay Clubhouse in Long Cove on Tile is important at the Bay. Tennis at Shelter and Bayview.

Many provided a spectacle as the Twin a Pine Junction by Mon Pelagia at Pinetree Subpoint all Twin Pine Junction and is Cove.

The Mon Pelagia Pinetree Mon Cove is the Subpoint Pine Mon by the Pine Cove. Shelter the Subpoint Junction, the Pinetree Mon Mon by the Pine Twin Twin. The Mon is the Shelter Subpoint Pine, Shelter Twin Mon Twin Twin Shelter Mon All Shelter by the Mon Mon Twin. In the Subpoint, the Twin Pine Mon Pine is Mon Subpoint and be Pine Twin Mon Mon be Subpoint Pine Subpoint is Mon to the Subpoint Pine.

The Mon Pine Subpoint Mon Pine a Subpoint Mon to Mon Pine Subpoint the Subpoint Mon Twin Subpoint Subpoint and All Shelter Subpoint.

The results of the two procedures were the total net operating costs for obstetrical dependent patients, other dependent patients and all other patients. Each of these costs was divided by the respective number of patients to obtain the cost per day. The cost per case was obtained by multiplying the cost per day times the average length of stay for each category.

There was one additional step in the case of the obstetrical patients. Since the charges from civilian doctors included costs for outpatient visits, laboratory tests and drugs issued from the doctor's office, the costs for military hospitals had to include the same items. Therefore, the average numbers of outpatient visits, outpatient laboratory tests and outpatient prescriptions for these patients were determined and the costs for these items were added to the cost per case figure. For both categories of dependents, $1.75 per day was deducted from the cost figures, since this amount was paid by the dependent and was therefore a deduction from the cost to the Government.

When the study was completed at the three hospitals, the cost figures were furnished to the Department of Defense where ". . . an overhead cost factor of $5.55 per day was added to each calculation. . . ."[17] This cost factor, although not the same amount, covered the same areas which had been included in the previous studies. It represented that portion of the costs for the following areas which were considered to be applicable to the in-patient care program:

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[17]U.S., Office of the Assistant Secretary of Defense, Letter with enclosure, from Shirley C. Fisk, M.D., Deputy Assistant Secretary (Health and Medical), to Hon. L. Mendel Rivers, Chairman, Subcommittee on Construction of Military Hospital Facilities, House of Representatives (Washington, D.C.: July 24, 1964). Printed in Hearings Before the Special Subcommittee on Construction of Military Hospital Facilities. 88th Cong., 2d Sess., 1964., p. 10342.

1. Depreciation of hospital buildings,

2. Military supply system overhead,

3. Education and training of medical personnel,

4. Offices of the Surgeons General overhead,

5. Insurance against fire, hurricane, etc.,

6. Retirement benefits of military personnel, and

7. Health, medical and burial insurance for military personnel and their dependents.[18]

As stated in the Introduction, every effort was made to ensure that the military costs were analyzed on a basis comparable to that used in civilian hospitals. In so doing, the above listed overhead costs, the military and civilian pay and many other costs were considered to be as equally applicable to the dependent as to the military man. Whether or not this is so is discussed in the next Chapter.

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[18]U.S., Department of Defense, Assistant Secretary of Defense, Health and Medical, Memorandum for the Surgeon General, Department of the Navy (Washington, D.C.: May 13, 1958), pp. 1-2 of Inclosure.

CHAPTER III

COULD IT HAVE BEEN DONE DIFFERENTLY?--AN ANALYSIS

Now that the reader has a knowledge of how the comparative cost study was conducted and how the costs were assigned to dependents, this chapter discusses the question as to whether the study could have been conducted differently. The main issues center on the purpose of the study and the general approach taken in arriving at an answer. As stated previously, the purpose of the study was to determine if it is cheaper for the Government to provide medical care for dependents in military or civilian hospitals. The approach was in conformance with the Bureau of the Budget Bulletin covering the comparison of government operated activities with similar or identical private activities.

The Bureau of the Budget states that

> . . . . It is the general policy of the administration that the Federal Government will not start or carry on any commercial-industrial activity to provide a service or product for its own use if such product or service can be procured from private enterprise through ordinary business channels,[1]

and then outlines the criteria to be followed in making the necessary comparisons. In view of this policy, the assumption can be made that if the Government can purchase obstetrical and other medical care for military dependents at a lower cost than the military hospitals can furnish it, the service should be purchased and the availability of medical care for

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[1]U.S., Executive Office of the President, Bureau of the Budget, Bulletin No. 60-2. Commercial-industrial activities of the Government ppoviding products or services for government use. (Washington, D.C.: September 21, 1959), p. 1.

dependents in military hospitals should be curtailed or discontinued.

The cost study should provide the data which is necessary to make a choice between the two alternatives. If, on the basis of the study, a decision is made to purchase the obstetrical care from civilian hospitals, the Government should realize some savings. If it doesn't, either the decision was wrong or the data furnished by the study was not completely valid. It appears to the author that the savings will not be realized for several reasons. First, the Government approach assumes that the Government activity will be discontinued in its entirety. This assumption is not valid with regard to the provision of medical care to dependents, since most of the treatment, diagnostic, administrative and housekeeping areas which are an integral part of any hospital will remain despite the discontinuance of service for a particular category of patients. Second, the costs were computed on a going-concern basis, i.e., the total costs of operating the various hospital areas were prorated on some basis to all patients using the areas. As in the first reason, by using this method of computation, no consideration was given to the fact that part of the costs will remain regardless of the loss of certain patients. Finally, the overhead costs added by the Department of Defense are not affected by the provision or nonprovision of medical care for dependents. Some of the costs are incurred in either case, some are never actually incurred and others are incurred depending on the numbers of military personnel required to ensure the security of our country.

A Business Approach

At this time, when there is an increasing emphasis on the use of business techniques in the government sphere, it might prove beneficial for

the Government to review the processes which many private businesses use in the consideration of various alternatives and to consider the use of these processes in the type of government study under review. Most managerial accounting books describe the processes. Professor Anthony points out that in this type of problem, often called a "trade-off problem," the manager attempts to find out whether one alternative has an acceptable trade-off compared with another in terms of its costs and the advantages which will be gained by adopting it.[2] Other authors present different examples, yet regardless of how they describe the processes, they all talk in terms of relevant costs.

Before proceeding further, it is necessary to establish the meaning of the word "relevant." Professor Horngren states that ". . . the relevant information is that expected future data which will differ between the alternatives."[3] He then elaborates on this statement as follows:

> . . . Historical, or past, data have no direct bearing on the decision. Historical data may be helpful in the formulation of predictions, but past figures, in themselves, are irrelevant simply because they are not the expected future data that managers must use in intelligent decision making. Decisions affect the future. Nothing can alter what has already happened; all past costs are down the drain, as far as current or future decisions are concerned.
>
> Of the expected future data, only those which will differ between alternatives are relevant. Any item is irrelevant if it will remain the same regardless of the alternative selected. . . .[4]

The evaluation of the alternatives in the business process is not limited to the quantitative factors; it also includes an assessment of the qualitative factors. The importance of the latter factors cannot be

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[2]Robert N. Anthony, Management Accounting: Text and Cases (3d ed.; Homewood, Illinois: Richard D. Irwin, Inc., 1964), p. 566.

[3]Charles T. Horngren, Accounting for Management Control: An Introduction (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1965), p. 324

[4]Ibid.

underestimated. In this respect, Professor Anthony states that "for most problems there are important factors that are not measurable; yet the final decision must take into account all differences between the alternatives being considered, both those measured and those not measured. . . ."[5]

In the dependent care cost study, every attempt was made to include and evaluate all of the measurable factors; however, no attempt was made to evaluate or to place any monetary value on the non-measurable factors. In addition, no attempt was made to evaluate or determine the relevancy oft he cost data which was used. If both the non-measurable factors and the relevancy aspect had been considered, the conduct of the study and the results might have been very different.

In the following sections, those qualitative factors which were not considered but which might affect the conduct of the study are presented and discussed. In addition, the various types of costs which were assigned to the alternatives are discussed with regard to their relevance and how they would be handled in the business approach.

The Military Mission of the Navy and Its Medical Department

The first and foremost qualitative consideration is the basic military nature of the duties assigned to the Navy and the Medical Department of the Navy. In discussing these duties, it is appropriate to consider the primary mission of the larger organization first and then to consider how the smaller organization contributes to accomplishment of this mission. In this regard, the National Security Act provides that ". . . the Navy shall be organized, trained, and equipped primarily for prompt and sustained

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[5]Anthony, op. cit., p. 564.

combat incident to operations at sea. It is responsible for the preparation of naval forces necessary for the effective prosecution of war. . . ."[6] Under this provision, the primary function of the Medical Department is to provide medical support for the operational forces of the Navy. It performs this function by maintaining the health of the Navy and Marine Corps through the care and treatment of the sick and injured, the prevention and control of diseases and injuries, the promotion of physical fitness, and the training of its personnel in the proper performance of their duties.[7]

In order for the Medical Department to fulfill the above listed responsibilities, it must be actively concerned with all phases of life in the Navy, and must make recommendations to and advise all echelons concerning matters which affect the health and well-being of members of the Navy and Marine Corps. If it is to furnish the most efficient medical and dental services, it needs (1) an established and functioning administrative structure, (2) adequate medical facilities, and (3) adequate numbers of personnel trained in the medical, dental and associated sciences.[8] Thus, the primary function of the Medical Department, and the only reason for its existence, is the performance of its military mission. As long as there is a need for the Navy as a security force, there will also be a need for a well-prepared and equipped Medical Department. This need will continue

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[6]U.S., United States Code, 1964 Edition, Title 10, Section 5012.

[7]U.S., Department of the Navy, Bureau of Medicine and Surgery, Manual of the Medical Department (Washington, D.C.: Government Printing Office, 1952, reprinted 1962), Article 1-2, Page Change 12.

[8]U.S., Department of the Navy, Bureau of Medicine and Surgery, Patient Treatment and Support Requirements, Medical Department of the Navy, A Report Prepared by the Bureau of Medicine and Surgery and the Office of Analysis and Review (Washington, D.C.: May, 1962). Printed in Hearings Before the Special Subcommittee on Construction of Military Hospital Facilities. 88th Cong., 2d Sess., 1964, p. 10021.

regardless of the existence of dependent patients.

The established and functioning administrative structure referred to above has been in existence since 1842, when the Bureau of Medicine and Surgery was established as the central agency of the Navy Medical Department. It is responsible ". . .for directing medical and dental services of and for the Navy and Marine Corps; initiating and integrating the policies, standards, and practices of the Medical Department; and directing activities concerned with its personnel, materiel, and public works."[9] The Organization Manual of the Bureau lists hundreds of duties which are performed by the various Bureau Codes in carrying out this responsibility. It is interesting to note that there are very few specific references to dependents in any of these duties.

The Chief of the Bureau, who is the Surgeon General of the Navy, is responsible for ". . . exercising over-all authority, direction, control and coordination necessary to carry out the mission and responsibility for the operating efficiency of assigned shore (field) activities."[10] These activities cover the wide range of areas which characterize the many and varied duties of the Medical Department. Included are naval hospitals, medical research laboratories, medical and dental technical schools, preventive medicine units, disease vector control units and others.[11]

The overhead factor which was added to each patient day cost included an amount to cover that portion of the cost of operating the Office of the Surgeon General (the Bureau) which was considered applicable to the

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[9]U.S., Department of the Navy, Bureau of Medicine and Surgery, Organization Manual, Bureau of Medicine and Surgery, Publication NAVMED P-1224 (Washington, D.C., December, 1964), p. vii (June 24, 1965).

[10]Ibid., p. 1-1 (June 24, 1965).

[11]Ibid., p. vii (June 24, 1965).

inpatient care program. Since the Bureau is the established central medical agency of a military organization and since it will continue to perform its duties as at the present despite any increase or decrease in the patient load, it is reasonable to assume that the cost incurred for its operation is a permanent and continuing expense. As such, under the business approach this cost would be considered irrelevant and would not be included as an add-on cost.

The Military Mission and Organization of U.S. Naval Hospitals

The second of the previously listed needs of the Medical Department was adequate medical facilities. Although there are a wide variety of these facilities, perhaps the one which is the best known and the most used by military personnel and their dependents is the naval hospital. At present, there are twenty-five U. S. Naval Hospitals in commission; each of these is a self-contained military command.

Like all other military units, a naval hospital also has a basic function to perform. The primary mission of the hospital is:

> (a) The care and treatment of sick and injured military personnel with the object of their expeditious return to duty.
>
> (b) The prompt disposition of those patients who require special treatment not satisfactorily available or who are found physically unfit for retention in the military service.[12]

The secondary mission of the hospital includes the care and treatment of dependents of military personnel and other authorized patients. However, by law, this care is furnished subject to the availability of space and facilities and the capabilities of the professional staff; the furnishing of the care may in no way interfere with the accomplishment of the primary

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[12] Manual of the Medical Department, op. cit., Article 11-1, Page Change 14.

mission of the hospital.

All naval hospitals are essentially designed for flexibility in structure and organized to permit rapid expansion to meet emergency military requirements. Despite wide variations in size, structure, and location, the hospitals all follow a common basic physical and organizational pattern. Each generally consists of (1) a single building or group of connected buildings which house the clinical and administrative functions, the ancillary services and the wards; and (2) a number of separate subsidiary units which house the storerooms, garages, officer and enlisted staff quarters, the laundry and other maintenance and service units.[13]

A technical definition of one of these hospitals will not distinguish it from most civilian hospitals. For instance, a naval hospital has been defined as

> . . . a fixed medical treatment facility primarily intended and appropriately staffed and equipped to provide relatively full diagnostic and therapeutic service in the field of general medicine and surgery, or in some circumscribed field or fields of restorative medical care, together with bed care, nursing, and dietetic service to patients requiring such care.[14]

This description could just as easily apply to a civilian hospital. Yet, there is one big difference between the two--the naval hospital is a military unit. As such, it must ". . . be organized and administered in accordance with law, U. S. Navy Regulations, and the orders of competent authority."[15] Because a naval hospital is a military institution, its staff is required to perform many functions which the staff of a civilian

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[13] U.S., Department of the Navy, Bureau of Naval Personnel, Medical Department Orientation, Publication NAVPERS 10816-B (Washington, D.C.: U.S. Government Printing Office, 1963), p. 64.

[14] Ibid., p. 63

[15] Manual of the Medical Department, op.cit., Article 11-4, Page Change 14.

hospital may never encounter. A few of these functions are the accomplishment of the detailed administrative and clerical procedures incident to the receipt, transfer, separation, discharge, reenlistment and retirement of military personnel; the preparation of reports and statistics on staff military and civilian personnel, budgetary and cost data, and inpatient and outpatient workload data for submission to higher authority; the holding of military inspections, investigations and courts-martial; and the provision of fire and police protection, [16] two services which civilian hospitals usually receive free of charge from the civilian communities.

The costs of performing these and many other functions were included in the cost study and were prorated between all patients. However, many of the costs of this type exist solely because of the military status of the hospital, rather than because of the numbers or types of patients. These costs will continue to be incurred as long as the hospital is in commission as a military unit.

While conducting the study, the total costs of operating the various areas were prorated between all patients using the respective areas. In the process, the relevancy of another group of costs, which the Americal Hospital Association refers to as the "readiness-to-serve" costs, was completely overlooked. The Association discusses these costs in terms of fixed and variable costs--the fixed costs are those which remain relatively the same, regardless of fluctuations in the volume of activity; while the variable costs are those which fluctuate in direct proportion to some measure of activity, in this case the patient load. The "readiness-to-serve" costs are those fixed costs which must be incurred to cover the minimum amount of

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[16] U.S., Department of the Navy, Bureau of Medicine and Surgery, BUMED INSTRUCTION 5450.4A, Organization Guide for U.S. Naval Hospitals (Washington, D.C., April 15, 1963).

service that the hospital expects to provide; however, the ". . . minimum of 'readiness-to-serve' cost is set at expected maximum levels of occupancy. . . ."[17]

The Association has stated the reason for these costs very concisely in the following paragraph:

> . . . the hospital must be ready each day to provide the quantity of services in each department that the patient load requires. Management generally determines the number of personnel which will be employed to provide patient services and retains the personnel over the daily varying patient loads rather than hiring and laying off employees as volume changes. This peculiarity of hospitals, coupled with the fact that the average monthly occupancy is fairly constant, means that hospitals are likely to have a large proportion of fixed costs in most departments and a small proportion of variable costs. . . .[18]

The "readiness-to-serve" cost approach and the preceding statement are equally applicable to naval hospitals. Just as civilian hospitals are committed to meeting the community needs for hospital care, so the naval hospitals are committed to meeting the Navy's needs for the same care. The latter commitment exists regardless of the categories of patients who use the facilities and regardless of the fact that the facilities are not used to the fullest possible capacity. The main considerations are that the facilities are available and, if possible, can be expanded to meet emergency military requirements.

The "readiness-to-serve" costs for naval hospitals cover a wide range of essential functions and areas. For instance, there must be an ambulance service to transport the military patients; admission and emergency units to receive them; wards, rooms and intensive care units to accomodate them; operating rooms to provide any necessary surgery for them; radiology and laboratory departments and other aids to assist in diagnosing

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[17] American Hospital Association, Cost Finding for Hospitals (Chicago: American Hospital Association, 1957), pp. 103-104.

[18] Ibid., p.4.

[illegible]

[illegible]

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them; physical and occupational therapy departments to aid in rehabilitating them; a dietary service to feed them; a pharmacy to provide the drugs necessary to treat them; and the medical and nursing staff to attend them. In addition to covering these and many other functions which contribute directly to patient care, the "readiness-to-serve" costs also cover many other important functions, which although not directly involved in patient care, are necessary if the care is to be given at all. These include the administration and operation of the personnel offices, the finance and supply areas, the medical records office and other administrative areas; the operation of the laundry and linen issue; the maintenance of buildings, grounds and equipment; the provision of housekeeping services; the operation of military enlisted and officers quarters; the maintenance and operation of the utilities production and distribution systems; and many others.

The Staffing of U. S. Naval Hospitals

The third of the previously listed needs of the Medical Department was adequate numbers of personnel trained in the medical, dental and associated sciences. If a naval hospital is to perform its assigned functions, it must have an appropriate share of these personnel. The hospital is concerned not only with the numbers of available personnel, but also with the qualifications and training of these personnel. Since there are different considerations for both of these areas, each is discussed separately--the staffing in this section and the training in the following section.

The staff of naval hospitals consists of both civilian and military personnel. The civilian employees work in such areas as the laundry, the maintenance shops, the dietary department, the utilities services, the

transportation section and the many administrative offices and/or units. In addition, some civilians work in the dependent wards, the labor and delivery rooms and the nursery and are thus directly involved in dependent inpatient care. These employees include the civilian nurses, nursing assistants and ward attendants.

The maximum authorized numbers and billets for civilian employees are established for each hospital by the central Bureau. Within this ceiling and the funds allotted for operation and maintenance, the hospital is permitted to establish such individual civilian positions as it considers best suits its needs.[19] The salaries for civilian employees are included in the total operating costs for the various areas in which they work. In the study, these costs were prorated between dependents and other patients, as applicable; however, many of the costs would be included in the "readiness-to-serve" costs and would continue to be incurred regardless of the status of the dependent patients.

Needless to say, military personnel work in the remainder of the billets of the hospital. These include complete staffing of the operating rooms, the laboratory and X-ray departments and other diagnostic units, the pharmacy, the admission and emergency units, the central supply room, the cast room, the military wards and many other areas which are used jointly by military and all other patients. In addition, military personnel are assigned to the various dependent inpatient areas.

All military personnel of the Medical Department are members of one of the five Corps which make up the Department. These Corps are (1) the Medical Corps which is comprised of the physicians (medical officers) of

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[19] Manual of the Medical Department, op. cit., Article 10-5, Page Change 9.

the Navy, including interns and residents; (2) the Dental Corps which is made up of the dentists (dental officers), also including interns and residents; (3) the Medical Service Corps which is composed of officers trained in various administrative, professional and scientific specialties, including chemists, pharmacists, physical and occupational therapists, dietitians, psychologists, bacteriologists, and others; (4) the Nurse Corps which is composed of the Navy nurses; and (5) the Hospital Corps which is composed of enlisted men and women who are trained to assist medical and dental officers, to serve aboard naval ships and with the Fleet Marine Forces, to furnish nursing care, and to perform duties as technical assistants in the various technical areas, such as the operating room, laboratory, X-ray department, electrocardiograph and electroencephalograph units, occupational and physical therapy, and many others.[20] The personnel of these Corps work together to fulfill the missions of the Medical Department and its component activities.

Since many military personnel actively participate in the treatment of dependent patients, the costs for their total pay and allowances were prorated between the dependents and all other patients in the study. However, in view of the manner in which the strengths of the different Corps are determined, it is questionable as to whether the military pay and allowances are relevant and are really a cost of treating the dependents. The maximum authorized strengths of all the Corps are established by law.[21] On 1 January of each year, the Secretary of the Navy is required to compute the strengths of the Corps within the guidelines established by the Congress.

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[20] Manual of the Medical Department, op. cit., Various Articles.

[21] United States Code, 1964 Edition, op. cit., Title 10, Section 5404 establishes the percentages for computation of strengths for the Medical, Dental, Medical Service and Nurse Corps. Section 5412 establishes a similar percentage for the Hospital Corps.

Under this procedure, the number of medical personnel is based solely on the active duty military strength of the Navy and Marine Corps. Although the law also provides for the care of dependents in naval hospitals, it makes no provisions for additional doctors, nurses or hospital corpsmen to furnish this care. Since the number of these personnel remains the same regardless of whether or not dependents are treated, the costs for their pay and allowances are irrelevant and should not be included in the alternatives being considered.

The Education and Training of Medical Department Personnel

It is not enough that there be adequate numbers of personnel to staff the Medical Department activities; there must also be highly trained personnel. Thus, there is a definite need for a training program. The primary purpose of the program is

> . . . to provide the Medical Department with the specialized professional and technical personnel it needs in all its Corps (Medical, Dental, Medical Service, Nurse, and Hospital) to fulfill its mission of providing medical support for the operational forces of the Navy. . . .[22]

In view of the high turnover of medical officers and hospital corpsmen, the role of the program in maintaining a steady supply of trained individuals takes on added importance.

The over-all program of the Medical Department is composed of programs for each of the Corps. The program for the Medical Corps has four purposes:

> (1) to achieve and maintain professional standard comparable to those enountered in superior medical facilities in civilian life;
>
> (2) to provide for the continuous advancement of naval medicine;

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[22] Medical Department Orientation, op. cit., p. 136.

(3) to attract and retain able physicians in Navy medicine; and

(4) to ensure that physicians have full opportunity for growth and utilization of their talents in their fields of special interest.[23]

Navy medical officers are encouraged to have both a clinical and a military medical specialty. Because the prevention and control of disease and injury reach into all phases of Navy life, all medical officers must also be competent in preventive medicine. To obtain a military medical specialty, medical officers attend special training programs conducted by the Navy in such functions as aviation medicine, submarine medicine, amphibious and field medicine and nuclear medicine. To obtain a clinical specialty, medical officers attend residency training programs in designated naval hospitals and in certain approved civilian hospitals.[24]

In addition to the military-medical and clinical specialty programs, the Navy conducts intern training programs in designated naval hospitals. In order for the intern and residency training programs to be approved by the Council on Medical Education and Hospitals of the American Medical Association and various American Specialty Boards, it is necessary that the Navy have an appropriate mixture of patients which includes the female and pediatric dependent patients. Without these latter patients, the approval of these programs could be jeopardized.[25]

The training programs of the Dental, Medical Service and Nurse Corps are not as detailed or comprehensive as the Medical Corps program. The

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[23]U.S., Department of the Navy, Bureau of Naval Personnel, Education and Training, 3d ed. Publication NAVPERS 10827-B (Washington, D.C., 1964), pp. 87-88.

[24]Ibid., pp. 88-89.

[25]U.S., House of Representatives, Committee on Armed Services, Hearings Before the Special Subcommittee on Construction of Military Hospital Facilities. Testimony of Rear Admiral E. C. Kenney. 88th Cong., 2d Sess., 1964, p. 10005.

Dental Corps does, however, conduct both intern, resident and postgraduate programs. The latter two programs are given to further train dental officers to provide treatment in the fields of general dentistry, oral surgery, prosthodontics, and periodontics.[26] Since dependents of naval personnel are not entitled to dental care, except as an adjunct to inpatient care or while they are located in remote areas, the training of dental officers must be considered a military function.

The program for the Medical Service Corps includes training in the administrative, military and allied science fields, at both military schools and civilian institutions. The medical allied science training is usually at the graduate level in such areas as psychology, chemistry, virology, hospital pharmacy and others. The administrative training includes the areas of hospital administration, business administration, comptrollership and hotel management.[27]

The program for the Nurse Corps provides training for the Navy nurses and, in addition, includes the payment for training of student nurses in civilian institutions as a means of getting the student to agree to serve on active duty upon completion of training. The advanced training for the Navy nurses includes study in nursing, nursing service, nursing education and anesthesia.[28]

The program of the Hospital Corps includes basic and specialized training for both Hospital Corpsmen and Dental Technicians. The basic training consists of instructing enlisted men in first aid, anatomy and physiology, hospital nursing care and/or dental procedures, and other basic

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[26] Education and Training, op. cit., p. 90.

[27] Medical Department Orientation, op. cit., p. 145.

[28] Ibid., pp. 145-146.

functions relating to hospital and dental patients. This is followed by on-the-job supervised training in either a naval hospital or a dental clinic. Later, the men are eligible to receive more specialized training in such technical areas as the operating room, X-ray, clinical laboratory, pharmacy, radioactive isotope, prosthetics, and other medical and dental technical specialties.[29] Although most of this training is conducted in naval hospitals, the basic purpose of the training is to prepare the individuals for service aboard combatant and hospital ships, at foreign shore stations or with Fleet Marine Force units.

For all of the Corps, the formal training programs are the means of providing the necessary professional and technical personnel for supporting the operational forces. The informal or on-the-job training programs are the means of maintaining the skills at an acceptable level of readiness. In view of the importance of the continuing need for both programs, it is very doubtful that the curtailment or discontinuance of treatment of dependents will cause the need to cease. The need will exist in any event. Therefore, the costs for training will be the same under both alternatives and as such are irrelevant to the decision.

A Consideration of the Overhead Cost Factor

The last area to be considered is the relevancy of the items which were included in the added overhead cost factor by the Department of Defense. Two of these items, the Offices of the Surgeons General overhead and the education and training of medical personnel, have already been discussed. The remaining five items will be discussed in this section.

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[29] Education and Training, op. cit., pp. 96-97.

The first item covered the depreciation of hospital buildings. With regard to the inclusion of depreciation figures when deciding between alternatives, Professor Anthony states that ". . . the depreciation charge is not relevant to the problem. It is a sunk cost, arising from actions taken in the past, and unaffected by any subsequent decision. . . ."[30] The Comptroller General of the United States likewise considered that the depreciation of laundry buildings should not be included as a cost when determining whether the Government should operate a hospital laundry or contract for the services from a commercial laundry. He based his findings on the fact that as long as the laundry facilities exist, the ". . . (depreciation) costs are being incurred by the Government regardless of whether or not the facilities are being used."[31] Since the naval hospital buildings would still be used after any curtailment of dependent care, it appears that the Comptroller General explanation is equally applicable to the alternatives under consideration and that the depreciation costs are irrelevant.

The second item covered the military supply system overhead. This service is currently provided by the Defense Supply Agency which is responsible for ". . . providing the most effective and economical support of common supplies and services to the military departments and other DoD components."[32] Despite the discontinuance of any part or all of dependent care, the Defense Supply Agency will continue to provide a service and the

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[30]Anthony, op. cit., p. 567.

[31]U.S., The Comptroller General of the United States, Potential Savings Through Use of Government-Owned Laundry Facilities at Hospitals Rather Than Use of Contract Services, Veterans Administration. Report to the Congress of the United States. Report No. B-133044 (Washington, D.C. September 20, 1965), p. 10.

[32]U.S., Department of Defense, Directive Number 5105.22, Defense Supply Agency (DSA) (Washington, D.C., November 6, 1961), p. 3.

naval hospital will continue to use the service. Since the estimated overhead cost applicable to naval hospitals would be the same or nearly the same in either event, the costs would be considered irrelevant.

The next two items covered the expected costs the Government would have to pay if it carried insurance to cover any losses from fire and hurricane and to cover the health, medical and burial benefits for military personnel and their dependents. The Government is self-insured in that it does not carry insurance to cover any of these items. Because of this, it makes no actual payments for any such coverage. Since there will not be any actual future costs for these items, neither one should be considered as being relevant to the alternatives.

The last item covered the amount estimated to cover the future retirement benefits of the military personnel working in the hospitals. This particular benefit is authorized by law. Once a military man decides that he will remain in the service until he is eligible for retirement, the benefit will accrue to him regardless of whether or not dependent care is given. It appears, then, that the cost would be the same under either alternative. As such, this cost would also be considered irrelevant.

After a review of all the overhead cost factors, it appears that these costs were added solely to put the military hospitals on a basis comparable to civilian hospitals. While this practice may be acceptable in government computations, it is doubtful that the practice would be acceptable to a business enterprise.

CHAPTER IV

CONCLUSIONS

Since World War II the Government has been concerned about, and has tried to prevent competition between business-type enterprises of Government agencies and civilian industry. In cases where such competition was thought to exist, the Government agency was required to compare the cost of operating its own activity with the cost to purchase the same service from private enterprise. In making the cost comparison, the agency was required to follow a Bureau of the Budget Bulletin which requires that all direct and indirect costs, whether funded or unfunded, be included in the Government's costs to the extent necessary to put the costs on a comparable basis.

Although it appears that the Bulletin only applies to business-type enterprises, there are instances where the guidelines have been applied to specific areas or components of non-industrial activities. One example is a comparative cost study which was conducted in 1964 by medical department personnel of the Army, Navy and Air Force. The purpose of the study was to compare the cost of furnishing obstetrical and other inpatient medical care to dependents of military personnel in military hospitals with the cost to buy the same services from civilian hospitals and physicians. It involved the collection of costs for fourteen military hospitals and the proration of these costs between the various categories of patients in order to compute both a cost per patient day and a cost per case.

In the study, the guidelines established by previous study groups were followed. All direct and hidden costs which could be identified with the operation of the hospitals were included. In addition, an overhead cost factor was added to each cost per patient day to cover both those cost items not discernible at the station level and those costs specified in the Bureau of the Budget Bulletin.

Underlying the study, and possibly the only reason for conducting it, is an assumption that if the service can be purchased at a lower cost than the military hospitals can furnish it, then the service should be purchased and the provision of the medical care in military hospitals should be curtailed or discontinued. If this is true, the study should provide the data necessary to make a choice between the two alternatives.

Since military dependents play a very important role in the military medical sphere and since the outcome of the study could adversely affect the availability of care for them in military facilities, it is imperative that the study be conducted in a manner that will produce valid and useful data. With this in mind, the purpose of this paper was to review the cost elements included in the study of naval hospitals to determine if, in fact, the study furnished the data necessary to make a decision. The review used the relevant cost approach employed by many civilian businesses when making decisions between alternatives. In the process, certain non-measurable or qualitative factors which were overlooked in the study were considered in order to determine their effect on the relevancy of the cost data.

As a result of using the relevant cost approach, it is concluded that the approach used in the dependent comparative cost study does not furnish the necessary data for making a decision between the two alternatives. While the study may furnish the costs assignable to dependents on a going

concern basis, it does not furnish a good picture of the savings which the Government could expect if a decision is made to use civilian facilities. This conclusion is based on the following considerations:

1. The primary mission of a naval hospital is the care and treatment of sick and injured active duty military patients. The hospital exists solely to accomplish this mission. Within the availability of facilities and the capabilities of the medical and dental staff, the secondary mission of the hospital includes the care and treatment of dependents of military personnel and other authorized patients. However, by law, the treatment of these additional patients may not interfere with the accomplishment of the primary mission and may be discontinued at any time that the facilities and staff are required to adequately care for the military patients.

2. In order to accomplish its primary mission, the naval hospital must maintain and staff a large number of medical, administrative and maintenance facilities, regardless of whether there are fifty patients or one hundred patients. This is due to the fact that it is the type of service activity which must be ready at all times to meet emergency military requirements and to meet peak patient loads, despite wide fluctuations in the patient load over a particular period. Since the hospital must maintain these "fixed" facilities, it incurs certain "readiness-to-serve" costs which are required to operate the facilities. These costs will continue to exist even though dependents are no longer provided care.

3. The Government approach overlooks the fixed nature of the "readiness-to-serve" costs. It requires that the total costs be used when making prorations between dependents and all other patients, despite the fact that many of the costs will continue if dependent care is discontinued.

4. The Government approach also includes the total pay and allowances of military personnel in the prorations. In view of the fact that the

numbers of military medical personnel are computed solely on the basis of the active duty military strength of the Navy and Marine Corps and since the numbers would remain the same if dependent care is discontinued, these costs do not meet the definition of relevant costs in the decision making process.

5. A review of the overhead costs reveals that none of these are relevant costs. The Office of the Surgeons General overhead, the education and training of military personnel, and the military supply system overhead are all necessary military functions which will remain the same with or without dependent care. The depreciation of buildings will continue to be incurred in either event. The estimated insurance costs will not result in future costs since there are no actual costs involved. And last, the entitlement to retirement benefits is a matter of law; the costs for these benefits will also continue to be incurred under both alternatives.

It is also concluded that a study conducted along the lines of the relevant cost approach used in civilian businesses would produce more meaningful and useful data. At a time when there is increasing emphasis on the use of business techniques in Government, the adoption of this particular approach may offer some benefit. Through the use of it, an attempt should be made to establish those basic costs which are necessary for the hospital to accomplish the primary military mission, assuming that no dependent care is given. These costs would be required in any event in order to maintain the hospital in a state of readiness to meet any emergency requirements. The true costs of treating dependents are those costs which must be added to the fixed primary mission costs to provide the required care.

At the same time, the non-measurable or qualitative benefits which accrue to the Navy should be considered. These include the maintenance of

the skills and versatility of the medical officers through a more diversified practice, the support of the intern and residency training programs, the provision of expansion capabilities, the maintenance of a state of readiness for emergency situations, and a more economical utilization of existing staff and facilities.

In any event, it appears that the present approach to the costing of dependent inpatient care in naval hospitals could stand a thorough revision. Only at such time as an objective study is made of the combined quantitative and qualitative factors will a clear picture of the cost of dependent medical care emerge. The accomplishment of the study would probably involve a considerable amount of work, but the results might be worth it.

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